

**State of Hawaii  
Department of Public Safety  
Health Care Division**

**Request for Proposals**

**RFP No.: PSD 06-HCD-44  
DENTAL SERVICES FOR INMATES  
ON THE  
ISLANDS OF  
MAUI AND KAUAI**

**May 26, 2006**

Note: If this RFP was downloaded from the State Procurement Office RFP Website each applicant must provide contact information to the RFP contact person for this RFP to be notified of any changes. For your convenience, you may download the [RFP Interest form](#), complete and e-mail or mail to the RFP contact person. The State shall not be responsible for any missing addenda, attachments or other information regarding the RFP if a proposal is submitted from an incomplete RFP.

**May 26 2006**

**REQUEST FOR PROPOSALS**

**DENTAL SERVICES FOR INMATES ON THE ISLANDS OF  
MAUI AND KAUAI  
RFP No. PSD 06-HCD-44**

The Department of Department of Public Safety, Health Care Division, is requesting proposals from qualified applicants to provide general dental services to inmates detained in the State's correctional institutions. The contract term will be for a two-year period commencing on the date indicated on the Notice to Proceed. A single contract will be awarded under this request for proposals.

Proposals must be postmarked by US mail before midnight on **June 26, 2006** or hand delivered by 4:30 p.m., Hawaii Standard Time (HST) at the drop off site that is designated on the following page.

Proposals postmarked after midnight on **June 26, 2006** or hand delivered after 4:30 p.m. HST on **June 26, 2006** will not be considered and will be returned to the applicant. There are no exceptions to this requirement.

The Health Care Division will conduct an orientation meeting on June 9, 2006 at 10:00 am to 11:00 am, HST, at 919 Ala Moana Boulevard, Room 413, Honolulu, Hawaii. All prospective applicants are encouraged to attend the orientation.

The deadline for submission of written questions is 4:30 p.m. HST on June 14, 2006. All written questions will receive a written response from the State by June 16, 2006.

Inquiries regarding this RFP should be directed to the RFP Contact Person, Mr. Marc Yamamoto at 919 Ala Moana Blvd., Room 413, or may be made by telephone to (808) 587-1215 or email at [marc.s.yamamoto@hawaii.gov](mailto:marc.s.yamamoto@hawaii.gov).

## PROPOSAL MAIL-IN AND DELIVERY INFORMATION SHEET

NUMBER OF COPIES TO BE SUBMITTED:

ALL MAIL-INS MUST BE POSTMARKED BY UNITED STATES POSTAL SERVICE (USPS)  
NO LATER THAN  
**June 26, 2006**  
**and received within ten (10) calendar days.**

Department of Public Safety  
Planning, Programming and Budget Office  
919 Ala Moana Blvd., Room 413  
Honolulu, Hawaii 96814

Mr. Marc Yamamoto  
For further info. or inquiries  
Phone: 587-1215  
Fax: 587-1244

ALL HAND DELIVERIES WILL BE ACCEPTED AT THE FOLLOWING SITE UNTIL  
4:30 P.M., **June 26, 2006.**

BE ADVISED: All mail-ins postmarked USPS after 12:00 midnight, **June 26, 2006**, will not be accepted for review and will be returned.

Hand deliveries will not be accepted after 4:30 p.m., **June 26, 2006.**

Deliveries by private mail services such as Fedex shall be considered hand deliveries and will not be accepted if received after 4:30 p.m., **June 26, 2006.**

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**Section 1**

**Administrative Overview**

# Section 1 Administrative Overview

Applicants are encouraged to read each section of the RFP thoroughly. While sections such as the administrative overview may appear similar among RFPs, state purchasing agencies may add additional information as applicable. It is the responsibility of the applicant to understand the requirements of *each* RFP.

## I. Procurement Timetable

Note that the procurement timetable represents the State’s best estimated schedule. Contract start dates may be subject to the issuance of a notice to proceed.

<b>Activity</b>	<b>Scheduled Date</b>
Issuance of Request for Information (RFI)	<u>April 26, 2006</u>
Due date for RFI responses	<u>May 5, 2006</u>
Public notice announcing RFP	<u>May 26, 2006</u>
Distribution of RFP	<u>May 26, 2006</u>
RFP orientation session	<u>June 9, 2006</u>
Closing date for submission of written questions for written responses	<u>June 14, 2006</u>
State purchasing agency's response to applicants' written questions	<u>June 16, 2006</u>
<b>Proposal submittal deadline</b>	<b><u>June 26, 2006</u></b>
Proposal evaluation period	<u>June 27–29, 2006</u>
Provider selection and award	<u>June 30, 2006</u>
Notice of statement of findings and decisions (approx. date)	<u>June 30, 2006</u>
<b>Contract start date</b>	<b><u>Date indicated on the Notice to Proceed</u></b>

## II. Request for Information Results

A request for information (RFI) was issued on April 26, 2006 inviting prospective applicants the opportunity to discuss questions regarding the scope of services, requirements of the subsequent request for proposals, as well as the type and range of services of the prospective applicant. Responses to the RFI were due on May 5, 2006, 4:30 p.m. (H.S.T.).

No responses were received as a result of our RFI.

### III. Website Reference

The State Procurement Office (SPO) website is [www.spo.hawaii.gov](http://www.spo.hawaii.gov)

	For	Click
1	Procurement of Health and Human Services	"Health and Human Services, Chapter 103F, HRS..."
2	RFP website	"Health and Human Services, Ch. 103F..." and "RFPs"
3	Hawaii Administrative Rules (HAR) for Procurement of Health and Human Services	"Statutes and Rules" and "Procurement of Health and Human Services"
4	Forms	"Health and Human Services, Ch. 103F..." and "For Private Providers" and "Forms"
5	Cost Principles	"Health and Human Services, Ch. 103F..." and "For Private Providers" and "Cost Principles"
6	Standard Contract -General Conditions	"Health and Human Services, Ch. 103F..." "For Private Providers" and "Contract Template – General Conditions"
7	Protest Forms/Procedures	"Health and Human Services, Ch. 103F..." and "For Private Providers" and "Protests"

#### Non-SPO websites

(Please note: website addresses may change from time to time. If a link is not active, try the State of Hawaii website at [www.hawaii.gov](http://www.hawaii.gov))

	For	Go to
8	Tax Clearance Forms (Department of Taxation Website)	<a href="http://www.hawaii.gov/tax/">http://www.hawaii.gov/tax/</a> click "Forms"
9	Wages and Labor Law Compliance, Section 103-055, HRS, (Hawaii State Legislature website)	<a href="http://www.capitol.hawaii.gov/">http://www.capitol.hawaii.gov/</a> click "Bill Status and Documents" and "Browse the HRS Sections."
10	Department of Commerce and Consumer Affairs, Business Registration	<a href="http://www.hawaii.gov/dcca">http://www.hawaii.gov/dcca</a> click "Business Registration"
11	Campaign Spending Commission	<a href="http://www.hawaii.gov/campaign">www.hawaii.gov/campaign</a>

### IV. Authority

This RFP is issued under the provisions of the Hawaii Revised Statutes (HRS), Chapter 103F and its administrative rules. All prospective applicants are charged with presumptive knowledge of all requirements of the cited authorities. Submission of a valid executed proposal by any prospective applicant shall constitute admission of such knowledge on the part of such prospective applicant.

**V. RFP Organization**

This RFP is organized into five sections:

**Section 1, Administrative Overview**--Provides applicants with an overview of the procurement process.

**Section 2, Service Specifications**--Provides applicants with a general description of the tasks to be performed, delineates applicant responsibilities, and defines deliverables (as applicable).

**Section 3, Proposal Application Instructions**--Describes the required format and content for the proposal application.

**Section 4, Proposal Evaluation**--Describes how proposals will be evaluated by the state purchasing agency.

**Section 5, Attachments** --Provides applicants with information and forms necessary to complete the application.

**VI. Contracting Office**

The Contracting Office is responsible for overseeing the contract(s) resulting from this RFP, including system operations, fiscal agent operations, and monitoring and assessing provider performance. The Contracting Office is:

**Wesley Mun**

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Department of Public Safety  
 919 Ala Moana Boulevard, Room 407  
 Honolulu, Hawaii 96814

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Phone	<b>587-2536</b>	Fax:	<b>587-3378</b>
(808)		(808)	

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**VII. Orientation**

An orientation for applicants in reference to the request for proposals will be held as follows:

**Date: June 9, 2006**      **Time: 10:00 a.m. to 11:00 a.m., H.S.T.**

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**Location: 919 Ala Moana Boulevard, Room 413  
 Honolulu, Hawaii 96813**

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Applicants are encouraged to submit written questions prior to the orientation. Impromptu questions will be permitted at the orientation and spontaneous answers provided at the state purchasing agency's discretion. However, answers provided at the orientation are only intended as general direction and may not represent the state purchasing agency's position. Formal official responses will be provided in writing. To ensure a written response, any oral questions should be submitted in writing following the close of the orientation, but no later than the submittal deadline for written questions indicated in the next paragraph (VII. Submission of Questions).

## **VIII. Submission of Questions**

Applicants may submit questions to the RFP Contact Person identified in Section 2 of this RFP. All written questions will receive a written response from the state purchasing agency.

Deadline for submission of written questions:

**Date:** June 14, 2006      **Time:** 4:30 p.m. HST

State agency responses to applicant written questions will be provided by:

**Date:** June 16, 2006

## **IX. Submission of Proposals**

**A. Forms/Formats** - Forms, with the exception of program specific requirements, may be found on the State Procurement Office website (See page 1-2, Websites Referred to in this RFP. Refer to the Proposal Application Checklist for the location of program specific forms.

- 1. Proposal Application Identification (Form SPO-H-200)**  
- Provides identification of the proposal.
- 2. Proposal Application Checklist** – Provides applicants with information on where to obtain the required forms; information on program specific requirements; which forms are required and the order in which all components should be assembled and submitted to the state purchasing agency.
- 3. Table of Contents** - A sample table of contents for proposals is located in Section 5, Attachments. This is a sample and meant as a guide. The table of contents may vary depending on the RFP.

**4. Proposal Application (Form SPO-H-200A)** - Applicant shall submit comprehensive narratives that addresses all of the issues contained in the Proposal Application Instructions, including a cost proposal/budget if required. (Refer to Section 3 of this RFP.)

**5. Tax Clearance** – A certified copy of a current valid tax clearance certificate issued by the State of Hawaii, Department of Taxation (DOTAX) and the Internal Revenue Service (IRS) will be required either at the time of proposal submittal or upon notice of award at the discretion of the purchasing agency.

Refer to Section 4, subparagraph III.A.1, Administrative Requirements, and the Proposal Application Checklist (located in Section 5) to determine whether the tax clearance is required at time of proposal submittal for this RFP. Tax clearance application may be obtained from the Department of Taxation website. (See paragraph II, Website Reference.)

**B. Program Specific Requirements** - Additional program specific requirements are included in Sections 2 and/or 3, Service Specifications and the Proposal Application Instructions, as applicable. If Federal and/or State certifications are required, they are listed on the Proposal Application Checklist located in Section 5.

**C. Multiple or Alternate Proposals** - Multiple or alternate proposals shall not be accepted unless specifically provided for in Section 2 of this RFP. In the event alternate proposals are not accepted and an applicant submits alternate proposals, but clearly indicates a primary proposal, it shall be considered for award as though it were the only proposal submitted by the applicant.

**D. Wages and Labor Law Compliance** - Before a provider enters into a service contract in excess of \$25,000, the provider shall certify that it complies with section 103-55, HRS, Wages, hours, and working conditions of employees of contractors performing services. Section 103-55, HRS may be obtained from the Hawaii State Legislature website. (See paragraph II, Website Reference.)

**E. Compliance with all Applicable State Business and Employment Laws.** All providers shall comply with all laws

governing entities doing business in the State. Prior to contracting, owners of all forms of business doing business in the state except sole proprietorships, charitable organizations unincorporated associations and foreign insurance companies be register and in good standing with the Department of Commerce and Consumer Affairs (DCCA), Business Registration Division. Foreign insurance companies must register with DCCA, Insurance Division. More information is on the DCCA website. (See paragraph II, Website Reference.)

**F. Campaign Contributions by State and County Contractors.** Contractors are hereby notified of the applicability of Section 11-205.5, HRS, which states that campaign contributions are prohibited from specified State or county government contractors during the term of the contract if the contractors are paid with funds appropriated by a legislative body. For more information, Act 203/2005 FAQs are available at the Campaign Spending Commission webpage. (See paragraph II, Website Reference.)

**G. Confidential Information** – If an applicant believes any portion of a proposal contains information that should be withheld as confidential, the applicant shall request in writing nondisclosure of designated proprietary data to be confidential and provide justification to support confidentiality. Such data shall accompany the proposal, be clearly marked, and shall be readily separable from the proposal to facilitate eventual public inspection of the non-confidential sections of the proposal.

**Note that price is not considered confidential and will not be withheld.**

**H. Proposal Submittal** - Proposals must be postmarked by USPS and received within ten days of the date designated on the Proposal mail-In and Deliver information sheet or hand delivered by the date and time designated on the Proposal Mail-In and Delivery Information Sheet attached to this RFP. Proposals shall be rejected when:

- postmarked after the designated date; or
- postmarked by the designated date but not received within 10 days; or
- If hand delivered, received after the designated date and time.

The number of copies required is located on the Proposal Mail-In and Delivery Information Sheet. Deliveries by private mail services such as FEDEX shall be considered hand

deliveries and shall be rejected if received after the submittal deadline. Dated USPS shipping labels are not considered postmarks.

Faxed proposals and/or submission of proposals on diskette/CD or transmission by e-mail, website or other electronic means **IS NOT permitted.**

## **X. Discussions with Applicants**

- A. Prior to Submittal Deadline.** Discussions may be conducted with potential applicants to promote understanding of the purchasing agency's requirements.
- B. After Proposal Submittal Deadline -** Discussions may be conducted with applicants whose proposals are determined to be reasonably susceptible of being selected for award, but proposals may be accepted without discussions, in accordance section 3-143-403, HAR.

## **XI. Opening of Proposals**

Upon receipt of proposal by a state purchasing agency at a designated location, proposals, modifications to proposals, and withdrawals of proposals shall be date-stamped, and when possible, time-stamped. All documents so received shall be held in a secure place by the state purchasing agency and not examined for evaluation purposes until the submittal deadline.

Procurement files shall be open to public inspection after a contract has been awarded and executed by all parties.

## **XII. Additional Materials and Documentation**

Upon request from the state purchasing agency, each applicant shall submit any additional materials and documentation reasonably required by the state purchasing agency in its evaluation of the proposals.

## **XIII. RFP Amendments**

The State reserves the right to amend this RFP at any time prior to the closing date for the final revised proposals.

#### **XIV. Final Revised Proposals**

The applicant's final revised proposal, *as applicable* to this RFP, must be postmarked by the date and time specified by the state purchasing agency and received within ten days or hand delivered by the date and time specified by the state purchasing agency. Final revised proposals shall be rejected when:

- Postmarked after the designated date; or
- Postmarked by the designated date but not received within ten days or
- If hand carried, received after the designated date and time.

If a final revised proposal is not submitted, the previous submittal shall be construed as their best and final offer/proposal. *The applicant shall submit ~~only~~ the section(s) of the proposal that are amended, along with the Proposal Application Identification Form (SPO-H-200).* After final revised proposals are received, final evaluations will be conducted for an award.

#### **XV. Cancellation of Request for Proposal**

The request for proposal may be canceled and any or all proposals may be rejected in whole or in part, when it is determined to be in the best interests of the State.

#### **XVI. Costs for Proposal Preparation**

Any costs incurred by applicants in preparing or submitting a proposal are the applicants' sole responsibility.

#### **XVII. Provider Participation in Planning**

Provider participation in a state purchasing agency's efforts to plan for or to purchase health and human services prior to the state purchasing agency's release of a request for proposals, including the sharing of information on community needs, best practices, and providers' resources, shall not disqualify providers from submitting proposals if conducted in accordance with sections 3-142-202 and 3-142-203 of the Hawaii Administrative Rules for Chapter 103F, HRS.

#### **XVIII. Rejection of Proposals**

The State reserves the right to consider as acceptable only those proposals submitted in accordance with all requirements set forth in this RFP and which demonstrate an understanding of the problems involved and comply with the service specifications. Any proposal

offering any other set of terms and conditions contradictory to those included in this RFP may be rejected without further notice.

A proposal may be automatically rejected for any one or more of the following reasons: (Relevant sections of the Hawaii Administrative Rules for Chapter 103F, HRS, are parenthesized)

- (1) Rejection for failure to cooperate or deal in good faith. (Section 3-141-201, HAR)
- (2) Rejection for inadequate accounting system. (Section 3-141-202, HAR)
- (3) Late proposals (Section 3-143-603, HAR)
- (4) Inadequate response to request for proposals (Section 3-143-609, HAR)
- (5) Proposal not responsive (Section 3-143-610 (1), HAR)
- (6) Applicant not responsible (Section 3-143-610 (2), HAR)

**XIX. Notice of Award**

A statement of findings and decision shall be provided to all applicants by mail upon completion of the evaluation of competitive purchase of service proposals.

Any agreement arising out of this solicitation is subject to the approval of the Department of the Attorney General as to form, and to all further approvals, including the approval of the Governor, required by statute, regulation, rule, order or other directive.

No work is to be undertaken by the awardee prior to the contract commencement date. The State of Hawaii is not liable for any costs incurred prior to the official starting date.

**XX. Protests**

Any applicant may file a protest against the awarding of the contract. The Notice of Protest form, SPO-H-801, is available on the SPO website. (See paragraph II, Website Reference.) Only the following matters may be protested:

- (1) A state purchasing agency's failure to follow procedures established by Chapter 103F of the Hawaii Revised Statutes;
- (2) A state purchasing agency's failure to follow any rule established by Chapter 103F of the Hawaii Revised Statutes; and

- (3) A state purchasing agency’s failure to follow any procedure, requirement, or evaluation criterion in a request for proposals issued by the state purchasing agency.

The Notice of Protest shall be postmarked by USPS or hand delivered to 1) the head of the state purchasing agency conducting the protested procurement and 2) the procurement officer who is conducting the procurement (as indicated below) within five working days of the postmark of the Notice of Findings and Decision sent to the protestor. Delivery services other than USPS shall be considered hand deliveries and considered submitted on the date of actual receipt by the state purchasing agency.

<b>Head of State Purchasing Agency</b>	<b>Procurement Officer</b>
Name: James L. Propotnick	Name: May Kawawaki Price
Title: Acting Director	Title: Administrative Services Officer
Mailing Address: 919 Ala Moana Boulevard, Room 400 Honolulu, Hawaii 96814	Mailing Address: 919 Ala Moana Boulevard, Room 413 Honolulu, Hawaii 96814
Business Address: same as above	Business Address: same as above

**XXI. Availability of Funds**

The award of a contract and any allowed renewal or extension thereof, is subject to allotments made by the Director of Finance, State of Hawaii, pursuant to Chapter 37, HRS, and subject to the availability of State and/or Federal funds.

**XXII. Monitoring and Evaluation**

The criteria by which the performance of the contract will be monitored and evaluated are:

- (1) Performance/Outcome Measures
- (2) Output Measures
- (3) Quality of Care/Quality of Services
- (4) Financial Management
- (5) Administrative Requirements

**XXIII. General and Special Conditions of Contract**

The general conditions that will be imposed contractually are on the SPO website. (See paragraph II, Website Reference). Special conditions may also be imposed contractually by the state purchasing agency, as deemed necessary.

**XXIV. Liability Insurance**

The Contractor shall maintain insurance acceptable to the State in full force and effect throughout the term of this contract. The policy or policies of insurance maintained by the Contractor shall provide the following limit(s) and coverage:

<u>Coverage</u>	<u>Limits</u>
<b>Commercial General Liability (occurrence form)</b>	\$1,000,000 combined single limit per occurrence for bodily injury and property damage
<b>Automobile, if applicable</b>	
Bodily injury	\$1,000,000/person
Property damage	\$1,000,000/occurrence \$1,000,000/accident
<b>Professional Liability, if applicable</b>	
	\$1,000,000/claim \$2,000,000 annual aggregate

Each insurance policy required by this contract shall contain the following clauses:

1. *“The insurance shall not be canceled, limited in scope of coverage or non-renewed until after 30 days written notice has been given to the State of Hawaii, Department of Public Safety, PPB Office, 919 Ala Moana Boulevard, Room 413, Honolulu, Hawaii 96814.”*
2. *“The State of Hawaii, Department of Public Safety, is added as an additional insured as respects to operations performed for the State of Hawaii.”*
3. *“It is agreed that any insurance maintained by the State of Hawaii will apply in excess of, and not contribute with, insurance provided by this policy.”*

Each insurance policy shall be written by insurance companies licensed to do business in the State or meet Section 431:8-301, HRS, if utilizing an insurance company not licensed by the State of Hawaii.

The Contractor agrees to deposit with the State of Hawaii, on or before the effective date of this contract, certificate(s) of insurance necessary to satisfy the State that the insurance provisions of this contract have been complied with and to keep such insurance in effect and the certificate(s) therefore on deposit with the State during the entire term of this contract. Upon request by the State, Contractor shall furnish a copy of the policy or policies.

Failure of the Contractor to provide and keep in force such insurance shall be regarded as material default under this contract, entitling the State to exercise any or all of the remedies provided in this contract for a default of the Contractor.

The procuring of such required policy or policies of insurance shall not be construed to limit Contractor's liability hereunder nor to fulfill the indemnification provisions and requirements of this contract. Notwithstanding said policy or policies of insurance, Contractor shall be obliged for the full and total amount of any damage, injury, or loss caused by negligence or neglect connected with this contract.

If the Contractor is authorized by the Department Coordinator to subcontract, subcontractor(s) is not excused from the indemnification and/or insurance provisions of this contract. In order to indemnify the State, the Contractor agrees to require its subcontractor(s) to obtain insurance in accordance with the insurance provisions of this contract.

**XXV. Cost Principles**

In order to promote uniform purchasing practices among state purchasing agencies procuring health and human services under Chapter 103F, HRS, state purchasing agencies will utilize standard cost principles outlined in Form SPO-H-201 which is available on the SPO website (see paragraph II, Website Reference). Nothing in this section shall be construed to create an exemption from any cost principle arising under federal law.

**XXVI. Campaign Contributions by State and County Contractors**

Contractors are hereby notified of the applicability of Section 11-205.5, HRS, which states that campaign contributions are prohibited from specified State or county government contractors during the term of the contract if the contractors are paid with funds appropriated by a legislative body.

# **Section 2**

## **Service Specifications**

## Section 2

# Service Specifications

### I. Introduction

#### A. Background

The Department of Public Safety, Health Care Division is responsible for the provision of health care to the individuals who are incarcerated throughout the State of Hawaii. This includes medical, dental and mental health services. The Maui Community Correctional Center (MCCC) and the Kauai Community Correctional Center must utilize outside vendor services to provide the dental services at each facility. The MCCC facility's population is approximately 338 inmates, while KCCC is at approximately 142 inmates. Both facilities house men and women of varied custody levels.

Both the HSNF and the HMSF have dedicated space for dental services.

#### B. Purpose or Need

The Department of Public Safety, Health Care Division requires the provision of dental services for the MCCC and the KCCC. The routine dental services required will meet the Department's Oral Care policy and procedure, as well as the National Commission on Correctional Health Care Dental standards.

#### C. Description of the goals of the service

The service provider shall provide on site dental clinics at the MCCC and the KCCC. The services involve general dentistry and a variety of acute and chronic oral health problems, including but not limited to restorative and prophylactic services. Inmate patients are screened and referred by the facility dental staff and/or nurses.

The Health Care Division will provide the clinical space. The service provider will provide all of the necessary equipment and dental supplies. The service provider shall record all evaluations, dental care, and treatments provided in the patients' individual facility dental records. The service provider shall be subject to all of the policies and procedures of the Health Care Division.

**D. Description of the target population to be served**

The Department of Public Safety, Health Care Division, seeks general dental services for inmates detained in the State's correctional institutions at the MCCC and KCCC.

**E. Geographic coverage of service**

The required dental services shall be provided at the MCCC on the island of Maui and the KCCC on the island of Kauai.

**F. Probable funding amounts, source, and period of availability**

The funds allocated for this contract is \$240,000 for each year of the contract, subject to the availability of funds after June 30, 2007.

**II. General Requirements**

**A. Specific qualifications or requirements, including but not limited to licensure or accreditation**

The applicant shall comply with the Chapter 103F, HRS Cost Principles for Purchases of Health and Human Services identified in SPO-H-201 (Effective 10/1/98), which can be found on the SPO website (See Section 5, POS Proposal Checklist, for the website address).

1. Applicants shall have:
  - a. A DDS or DMD degree;
  - b. A current Hawaii dental license;
  - c. Practice experience in an institutional setting, preferred but not required;
  - d. Experience in correctional dentistry, preferred but not required (significant correctional dentistry experience during training will be considered); and
  - e. A minimum of two recent references.
2. Service provider shall be responsible for providing all necessary equipment and dental supplies necessary for providing dental services to inmates at the MCCC and the KCCC.
3. Service provider shall not be an employee of the State of Hawaii, Department of Public Safety.

**B. Secondary purchaser participation**

(Refer to §3-143-608, HAR)

After-the-fact secondary purchases will be allowed.

**C. Multiple or alternate proposals**

(Refer to §3-143-605, HAR)

Allowed             Unallowed

**D. Single or multiple contracts to be awarded**

(Refer to §3-143-206, HAR)

Single             Multiple             Single & Multiple

Criteria for multiple awards:

**E. Single or multi-term contracts to be awarded**

(Refer to §3-149-302, HAR)

Single term ( $\leq$  2 yrs)             Multi-term ( $>$  2 yrs.)

Contract terms:

The service provider shall enter into contract for the **two-year** period commencing upon the date indicated on the Notice to Proceed. Unless terminated, the contract may be extended for not more than three additional twelve-month periods or portions thereof without the necessity of rebidding, if mutually agreed upon in writing.

**F. RFP contact person**

The individual listed below is the sole point of contact from the date of release of this RFP until the selection of the successful provider or providers. Written questions should be submitted to the RFP contact person and received on or before the day and time specified in Section 1, paragraph I (Procurement Timetable) of this RFP.

Mr. Marc Yamamoto, PPB-Purchasing Specialist  
Department of Public Safety  
919 Ala Moana Blvd., Rm. 413  
Honolulu, Hawaii 96814  
Phone: (808) 587-1215 Fax: (808) 587-1244

### III. Scope of Work

The scope of work encompasses the following tasks and responsibilities:

#### A. Service Activities (Minimum and/or mandatory tasks and responsibilities)

1. Service provider shall provide dental services at a minimum of four (4) days (or mutually determined number of days based on patient needs) a month to inmates at the following facilities on the islands of Maui and Kauai.

Maui Community Correctional Center (MCCC)  
600 Waiale Drive  
Wailuku, Hawaii 96793

Point of Contact: Carol Payne, Clinic Services Administrator  
Phone: 243-5864

Kauai Community Correctional Center (KCCC)  
5350 Kuhio Highway  
Lihue, Hawaii 96766

Point of Contact: Becky Rocco, Clinic Services Administrator  
Phone: 241-3067

2. Service provider shall:
  - a. Provide general dental services and education related to oral health and hygiene according to *the Department of Public Safety, Health Care Division, Policy and Procedures for Oral Care* attached hereto as Attachment C.
  - b. Examine and diagnose dental and oral diseases.
  - c. Render indicated treatment for oral and dental diseases, including but not limited to oral diagnoses, dental prostheses, restorative dentistry, oral surgery, treatment of pain and infection in the oral cavity, taking of x-rays, and prescription medications according to the Department of Public Safety policies and procedures.
  - d. Maintain records of all care and treatment rendered according to the Department of Public Safety format.
  - e. Contractor shall be responsible for payment on all referrals.

- f. Review quarterly dental staff meeting minutes to keep abreast of all current practices of dentistry in the correctional system and express concerns to the Health Care Division Administrator.
  - g. Contractor shall provide the dental services associated with dental prostheses and will invoice the State for reimbursement for any Laboratory fees related to the fabrication of the prostheses. Patients will be required to complete the Prosthesis Purchase Agreement form per *the Department of Public Safety, Health Care Division, Policy and Procedures for Prostheses* attached hereto as Attachment D.
  - h. Develop and implement infection control practices in compliance with OSHA and HIOSHA guidelines. Includes standard precautions, adequately cleaning and sterilization of non-disposable dental instruments and performing monthly autoclave spore counts.
  - i. Administer and maintain the Inmate Medical Co-Payment Plan as it pertains to dental services per *the Department of Public Safety, Health Care Division, Policy and Procedures for Inmate Medical Co-Payment Plan* attached hereto as Attachment E.
  - j. Conduct regular sharps counts and monthly tool inventory counts per *the Department of Public Safety, Health Care Division, Policy and Procedures for Tool/Equipment Control* attached hereto as Attachment F. Provide documentation of above counts to the Clinic Services Administrator.
  - k. Be familiar with and adhere to all Departmental policies and procedures.
3. The service provider shall receive general supervision from the Department's Health Care Division Administrator.
4. Lockdowns
- a. Scheduled Lockdowns: Service provider will be notified in advance of scheduled lockdowns. Service provider shall arrange with the facility's health care section to have patients called out ahead of the scheduled lock down, so that dental services will be provided on a continuous basis.

- b. **Unscheduled Lockdowns:** The service provider shall utilize this time by doing internal audits on dental procedures and documentations.
- 5. **Travel Time.** Service provider shall not be paid for travel time.
- 6. **Additional Hours.** Dentist shall work only the approved or agreed upon hours for the HCF. Written permission from the Health Care Division Administrator shall be obtained before working additional hours.

**B. Management Requirements (Minimum and/or mandatory requirements)**

**1) Personnel**

The Provider and/or Sub-Provider shall notify each of its employees as well as employees of any subcontractors who provide services to any person committed to the custody of the Director of Public Safety for imprisonment pursuant to Chapter 706, Hawaii Revised Statutes (HRS), including a probationer serving a term of imprisonment pursuant to Section 706-624(2)(a), HRS and a misdemeanor or petty misdemeanor sentenced pursuant to Section 706-663, HRS, about the Hawaii Revised Statutes Section 707-731 relating to sexual assault in the second degree and Section 707-732, relating to sexual assault in the third degree. In addition, the Provider and any subcontractor shall maintain in each of the aforementioned employees and employees of any subcontractors' file, written documentation that the employee has received notice of the statutes.

The Provider and/or Sub-Provider shall employ staff that is suitable to deal with these offenders. The Provider and/or Sub-Provider shall not use persons currently serving a criminal sentence, including any on furlough from a correctional facility, on probation, on parole, or under the terms of a DAG/DANC plea. Any employee with a criminal history shall be subject to review and approval by the Department. The Department of Public Safety will review and agree to the employment of the service provider's staff and sub-providers, in writing. Upon request, the Provider and/or Sub-Provider shall submit any information necessary to determine whether approval will, at the discretion of the Department, be granted. Any changes to staff and/or Sub-Providers shall be subject to the prior written approval of the Department.

**2) Administrative**

- a. Service provider shall operate their program in accordance with the rules, regulations, and policies of the Department of Public Safety.
- b. Service provider is required to meet the qualifying requirements specified in Chapter 103F, Hawaii Revised Statutes.
- c. Service provider shall maintain and show proof of a liability insurance policy of at least one million dollars. The Department of Public Safety shall be named as an additional insured and shall be notified at least thirty (30) days prior to cancellation.
- d. Service provider shall provide the Corrections Health Care Administrator a copy of the current dental license, DEA certificate, and CPR certification for any dental providers servicing the contract. The Service provider will provide these credentials for additional dental providers that may be added to service this contract and as existing licenses and certificates are renewed. The Health Care Division requires that all current credentials be maintained in its files.

**3) Quality assurance and evaluation specifications**

*This section is not applicable to this RFP.*

**4) Output and performance/outcome measurements**

*This section is not applicable to this RFP.*

**5) Reporting requirements for program and fiscal data**

- a. Service provider shall ensure that an informed consent Form DOC 0427 be completed and signed by the inmate prior to any dental procedures such as tooth extractions, root canal therapy, or other surgical procedures are performed per *the Department of Public Safety, Health Care Division, Policy and Procedures for Informed Consent* attached hereto as Attachment G.
- b. Service provider shall ensure that the facility nurse records on Form DOC 0417, "Refusal to Consent to Medical or Surgical Treatment", any inmate's refusal for treatment.

- b. Service provider shall submit quarterly reports of dental services rendered using Form DOC 0431b (Attachment C). Service provider shall submit three months of Dental Statistics Monthly reports on a quarterly basis along with a written summary.

**6) Pricing structure or pricing methodology to be used**

Applicant shall submit a cost proposal utilizing the pricing structure designated by the state purchasing agency. The cost proposal shall be attached to the POS Proposal Application.

**7) Units of service and unit rate**

**Pricing Structure Based on Unit of Service – Negotiated**

Pricing shall be based on a fee schedule/unit of service pricing structure or a capitated, per patient per month rate, for services described in *the Department of Public Safety's Policies and Procedures relating to Oral Care*, Attachment C. The rates submitted shall be subject to negotiation.

Service provider shall submit monthly itemized invoices, original and three copies, which detail the following:

1. Inmate name;
2. Facility of inmate;
3. Procedures completed;
4. Date of the procedure; and
5. Charge amount

The service provider shall not be compensated for downtime. However, once the Dental Clinic is scheduled, the nurse supervisor and/or the Facility Dental Staff shall make every effort to ensure that enough inmate patients are available on the list.

If a facility wide lockdown is scheduled, the Dental Clinic may be rescheduled and the service provider shall be notified in a timely manner.

**IV. Facilities**

*This section is not applicable to this RFP.*

## **Section 3**

# **Proposal Application Instructions**

## Section 3

# Proposal Application Instructions

### General instructions for completing applications:

- *Proposal Applications shall be submitted to the state purchasing agency using the prescribed format outlined in this section.*
- *The numerical outline for the application, the titles/subtitles, and the applicant organization and RFP identification information on the top right hand corner of each page should be retained. The instructions for each section however may be omitted.*
- *Page numbering of the Proposal Application should be consecutive, beginning with page one and continuing through for each section. See sample table of contents in Section 5.*
- *Proposals may be submitted in a three ring binder (Optional).*
- *Tabbing of sections (Recommended).*
- *Applicants must also include a Table of Contents with the Proposal Application. A sample format is reflected in Section 5, Attachment B of this RFP.*
- *A written response is required for **each** item unless indicated otherwise. Failure to answer any of the items will impact upon an applicant's score.*
- *Applicants are **strongly** encouraged to review evaluation criteria in Section 4, Proposal Evaluation when completing the proposal.*
- *This form (SPO-H-200A) is available on the SPO website (see Section 1, paragraph II, Website Reference). However, the form will not include items specific to each RFP. If using the website form, the applicant must include all items listed in this section.*

### The Proposal Application comprises the following sections:

- *Proposal Application Identification Form*
- *Table of Contents*
- *Program Overview*
- *Experience and Capability*
- *Project Organization and Staffing*
- *Service Delivery*
- *Financial*
- *Other*

#### I. **Background and Summary**

*This section is not applicable to this RFP.*

#### II. **Experience and Capability**

##### A. **Necessary Skills and Experience**

The applicant shall demonstrate that it has the necessary skills, abilities, knowledge of, and experience relating to the delivery of the proposed services. The applicant shall also provide a listing of verifiable experience with projects or contracts for the most recent five years that are pertinent to the proposed services.

**B. Quality Assurance and Evaluation**

*This section is not applicable to this RFP.*

**C. Coordination of Services**

*This section is not applicable to this RFP.*

**D. Facilities**

*This section is not applicable to this RFP.*

**III. Personnel: Project Organization and Staffing**

**A. Proposed Staffing**

*This section is not applicable to this RFP.*

**B. Staff Qualifications**

*This section is not applicable to this RFP.*

**IV. Service Delivery**

The Service Delivery Section shall include a detailed discussion of the applicant's approach to applicable service activities and management requirements from Section 2, Item III. - Scope of Work, including (if indicated) a work plan of all service activities and tasks to be completed, related work assignments/responsibilities and timelines/schedules.

Please discuss and attach sample reports indicating the dental work provided to each inmate. This report shall be provided to the Department on a timely basis.

**V. Financial**

**A. Pricing Structure**

Applicant shall submit a cost proposal utilizing the pricing structure designated by the state purchasing agency. The cost proposal shall be attached to the POS Proposal Application.

Pricing Structure Based on Negotiated Unit of Service Rate

In order to determine a price (unit rate) for a unit of service, the applicant and state purchasing agency negotiate the total costs (including agency administration) for operating a program at a specific capacity and divide by the total number of units of service that the program can produce at that capacity.

Applicant shall submit a fee schedule by procedure or an estimated fee to provide the services listed under Attachment C. All rates shall include all costs associated with carry out the terms of the contract, and all applicable taxes. The State reserves the right to negotiate with the applicant on any or all fees proposed.

All budget forms, instructions and samples are located on the SPO website (see the POS Proposal Checklist in Section 5 for website address). The following budget form(s) shall be submitted with the POS Proposal Application:

***Budget forms are not required with this RFP.***

**VI. Other**

**A. Litigation**

The applicant shall disclose any pending litigation to which they are a party, including the disclosure of any outstanding judgment. If applicable, please explain.

**Section 4**

**Proposal Evaluation**

# Section 4 Proposal Evaluation

## I. Introduction

The evaluation of proposals received in response to the RFP will be conducted comprehensively, fairly and impartially. Structural, quantitative scoring techniques will be utilized to maximize the objectivity of the evaluation.

## II. Evaluation Process

The procurement officer or an evaluation committee of designated reviewers selected by the head of the state purchasing agency or procurement officer shall review and evaluate proposals. When an evaluation committee is utilized, the committee will be comprised of individuals with experience in, knowledge of, and program responsibility for program service and financing.

The evaluation will be conducted in three phases as follows:

- Phase 1 - Evaluation of Proposal Requirements
- Phase 2 - Evaluation of Proposal Application
- Phase 3 - Recommendation for Award

### Evaluation Categories and Thresholds

<u>Evaluation Categories</u>		<u>Possible Points</u>
<b><i>Administrative Requirements</i></b>		<b>Pass or Rejected</b>
<b><i>Proposal Application</i></b>		<b>100 Points</b>
Program Overview	Not Applicable	
Experience and Capability	20 points	
Project Organization and Staffing	Not Applicable	
Service Delivery	40 points	
Financial	40 Points	
<b>TOTAL POSSIBLE POINTS</b>		<b>100 Points</b>

### **III. Evaluation Criteria**

#### **Phase 1 - Evaluation of Proposal Requirements**

##### **1. Administrative Requirements**

##### **2. Proposal Application Requirements**

- Proposal Application Identification Form (Form SPO-H-200)
- Table of Contents
- Program Overview
- Experience and Capability
- Project Organization and Staffing
- Service Delivery
- Financial (All required forms and documents)
- Program Specific Requirements (as applicable)

#### **Phase 2 - Evaluation of Proposal Application (100 Points)**

1. ***Program Overview:*** No points are assigned to Program Overview. The intent is to give the applicant an opportunity orient evaluators as to the service(s) being offered.

Not applicable to this RFP.

2. ***Experience and Capability (20 Points)***

The State will evaluate the applicant's experience and capability relevant to the proposal contract, which shall include:

- Demonstrated skills, abilities, and knowledge relating to the delivery of the proposed services.
- Sufficiency of quality assurance and evaluation plans for the proposed services, including methodology.

3. ***Project Organization and Staffing (Not Applicable to this RFP)***

The State will evaluate the applicant's overall staffing approach to the service that shall include:

**A. Staffing**

Not applicable to this RFP.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**B. Project Organization**

Not applicable to this RFP.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**4. Service Delivery (40 Points)**

*Evaluation criteria for this section will assess the applicant’s approach to the service activities and management requirements outlined in the Proposal Application.*

**5. Financial (40 Points)**

Pricing structure based on negotiated unit of service rate

- Competitiveness and reasonableness of unit of service rate, as applicable
- Applicants proposal budget is reasonable, given program resources and operational capacity.

**Phase 3 - Recommendation for Award**

Each notice of award shall contain a statement of findings and decision for the award or non-award of the contract to each applicant.

# Section 5

## Attachments

- A Competitive POS Application Checklist
- B POS Proposal Application - Sample Table of Contents
- C Department of Public Safety, Health Care Division, Policy and Procedures for Oral Care.
- D. Department of Public Safety, Health Care Division, Policy and Procedures for Prostheses.
- E. Department of Public Safety, Health Care Division, Policy and Procedures for Inmate Medical Co-Payment Plan.
- F. Department of Public Safety, Health Care Division, Policy and Procedures for Tools/Equipment Control.
- G. Department of Public Safety, Health Care Division, Policy and Procedures for Informed Consent.

## Proposal Application Checklist

Applicant: \_\_\_\_\_

RFP No.: \_\_\_\_\_

The applicant's proposal must contain the following components in the order shown below. This checklist must be signed, dated and returned to the purchasing agency as part of the Proposal Application. SPOH forms are on the SPO website. See Section 1, paragraph II Website Reference.\*

Item	Reference in RFP	Format/Instructions Provided	Required by Purchasing Agency	Completed by Applicant
<b>General:</b>				
Proposal Application Identification Form (SPO-H-200)	Section 1, RFP	SPO Website*	<b>X</b>	
Proposal Application Checklist	Section 1, RFP	Attachment A	<b>X</b>	
Table of Contents	Section 5, RFP	Section 5, RFP	<b>X</b>	
Proposal Application (SPO-H-200A)	Section 3, RFP	SPO Website*	<b>X</b>	
Tax Clearance Certificate (Form A-6)	Section 1, RFP	Dept. of Taxation Website (Link on SPO website)*		
Cost Proposal (Budget)				
SPO-H-205	Section 3, RFP	SPO Website*		
SPO-H-205A	Section 3, RFP	SPO Website* Special Instructions are in Section 5		
SPO-H-205B	Section 3, RFP,	SPO Website* Special Instructions are in Section 5		
SPO-H-206A	Section 3, RFP	SPO Website*		
SPO-H-206B	Section 3, RFP	SPO Website*		
SPO-H-206C	Section 3, RFP	SPO Website*		
SPO-H-206D	Section 3, RFP	SPO Website*		
SPO-H-206E	Section 3, RFP	SPO Website*		
SPO-H-206F	Section 3, RFP	SPO Website*		
SPO-H-206G	Section 3, RFP	SPO Website*		
SPO-H-206H	Section 3, RFP	SPO Website*		
SPO-H-206I	Section 3, RFP	SPO Website*		
SPO-H-206J	Section 3, RFP	SPO Website*		
<b>Certifications:</b>				
<b>Federal Certifications</b>		Section 5, RFP		
Debarment & Suspension		Section 5, RFP		
Drug Free Workplace		Section 5, RFP		
Lobbying		Section 5, RFP		
Program Fraud Civil Remedies Act		Section 5, RFP		
Environmental Tobacco Smoke		Section 5, RFP		
<b>Program Specific Requirements:</b>				

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Date

Sample

## Proposal Application Table of Contents

<b>I.</b>	<b>Program Overview</b> .....	<b>1</b>
<b>II.</b>	<b>Experience and Capability</b> .....	<b>1</b>
	<b>A.</b> Necessary Skills .....	<b>2</b>
	<b>B.</b> Experience.....	<b>4</b>
	<b>C.</b> Quality Assurance and Evaluation.....	<b>5</b>
	<b>D.</b> Coordination of Services.....	<b>6</b>
	<b>E.</b> Facilities .....	<b>6</b>
<b>III.</b>	<b>Project Organization and Staffing</b> .....	<b>7</b>
	<b>A.</b> Staffing.....	<b>7</b>
	1. Proposed Staffing.....	<b>7</b>
	2. Staff Qualifications .....	<b>9</b>
	<b>B.</b> Project Organization .....	<b>10</b>
	1. Supervision and Training.....	<b>10</b>
	2. Organization Chart (Program & Organization-wide) (See Attachments for Organization Charts)	
<b>IV.</b>	<b>Service Delivery</b> .....	<b>12</b>
<b>V.</b>	<b>Financial</b> .....	<b>20</b>
	See Attachments for Cost Proposal	
<b>VI.</b>	<b>Litigation</b> .....	<b>20</b>
<b>VII.</b>	<b>Attachments</b>	
	<b>A.</b> Cost Proposal	
	SPO-H-205 Proposal Budget	
	SPO-H-206A Budget Justification - Personnel: Salaries & Wages	
	SPO-H-206B Budget Justification - Personnel: Payroll Taxes and Assessments, and Fringe Benefits	
	SPO-H-206C Budget Justification - Travel: Interisland	
	SPO-H-206E Budget Justification - Contractual Services – Administrative	
	<b>B.</b> Other Financial Related Materials	
	Financial Audit for fiscal year ended June 30, 1996	
	<b>C.</b> Organization Chart	
	Program	
	Organization-wide	
	<b>D.</b> Performance and Output Measurement Tables	
	Table A	
	Table B	
	Table C	
	<b>E.</b> Program Specific Requirements	

	<b>DEPARTMENT OF PUBLIC SAFETY</b>	<b>EFFECTIVE DATE:</b> 05/12/2003	<b>POLICY NO.:</b> COR.10.1E.06
	<b>CORRECTIONS ADMINISTRATION</b> <b>POLICY AND PROCEDURES</b>	<b>SUPERSEDES (Policy No. &amp; Date):</b> COR.10D.15 01/09/98	
	<b>SUBJECT:</b> <p style="text-align: center;"><b>ORAL CARE</b></p>	Page 1 of 5	

No. 2003-468

1.0 **PURPOSE**

To provide oral care to inmates under the direction and supervision of a dentist licensed in the State.

2.0 **REFERENCES AND DEFINITIONS**

.1 References

- a. HRS, Section 26-14.6, Department of Public Safety; and Section 353C-2, Director of Public Safety, Powers and Duties.
- b. National Commission on Correctional Health Care Standards for Prisons and Jails, (2003), Oral Care.
- c. American Dental Association.
- d. American Correctional Association Standards for Adult Local Detention Facilities, (1991), dental Screening and Examination.
- e. Department of Public Safety Policy and Procedures Manual, COR.10A.16, Inmates Requesting Private Medical Care Provider. COR.10.1G.11, Prostheses  
COR.10.1H.05, The Transfer of Medical Records.

.2 Definitions

- a. Universal Dental Recording System: A mean of identifying teeth by number.
- b. Prosthetics: Artificial devices to replace missing body parts; in this case, dentures, bridges, etc.

3.0 **POLICY**

- .1 Dental examinations and treatments for inmates shall be performed by, and under the direction and supervision of, a dentist licensed to practice in the Sate of Hawaii.

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- .2 Dental care of inmates shall be timely and includes immediate access for urgent or painful conditions. The inmate's serious urgent and emergent dental needs shall be met.

**4.0 PROCEDURES**

- .1 Dental screening of newly admitted inmates shall occur within fourteen (14) days of admission into the Department of Public Safety (PSD) jail facilities and seven (7) days after admission to prison facilities. Inmates who transfer from one PSD facility to another who received a dental screen while at the sending facility do not require a new screening at the receiving facility if the documentation in the dental record is received within the 14 to 7 days respectively.
- .2 The dental screening shall include visual observation of the teeth and gums, noting any gross abnormalities which require immediate referral to a dentist. Health staff with documented training by a dentist can perform dental screens. The screening shall be recorded in the dental record.
- .3 Instructions in oral hygiene and preventive oral education are given within one (1) month of admission by a dentist, dental hygienist, or health staff with documented training by a dentist.
- .4 A dentist shall perform a dental examination on all inmates within thirty (30) days of admission to a PSD prison facility and within one (1) year of admission to a PSD jail facility. Inmates who transfer from one PSD facility to another who received a dental screen while at the sending facility do not require a new examination at the receiving facility if the documentation in the dental record transfers with the inmate.

Inmates who are re-admitted and who received a dental examination and treatments within the past year do not require a new examination unless so determined by the supervising dentist.

- .5 Dental examinations shall include taking the patient's dental history, and extraoral head and neck examination, charting of teeth and examination of hard and soft tissue of the oral cavity with a mouth mirror, explorer and adequate illumination. The examination results shall be recorded on Form DOC 0424 Dental Examination (Attachment A) utilizing a number system, such as the Universal Dental Recording System (e.g., 1-32, A -T).

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- .6 Oral treatment shall be prioritized for emergencies, acute injuries to the teeth, acute injuries to the oro-facial complex, infection control, pain management, proper mastication and maintaining the patients' health status.
- .7 Bitewing x-rays and additional radiographs may be taken at the time of the patient's first treatment appointment and thereafter as indicated.
- .8 Each inmate shall have access to the preventive benefits of fluorides in a form determined by the dentist to be appropriate for the needs of the individual.
- .9 Extractions shall be performed in a manner consistent with community standards of care and adhering to the American dental association's clinical guidelines. Extractions are limited to the following:
  - 1. Non-restorable teeth;
  - 2. Periodontally compromised teeth; and
  - 3. Severe, acute or chronic infection.

Informed patient consent for extractions is required on DOC 0427, Consent to Operation, Post Operative Care, medical Treatment, Anesthesia or Other Procedure (Attachment B).
- .10 Inmates can seek private dental care at their own expense under COR.10A.16, Inmates Requesting Private Medical Care Provider. For security reasons, dental staff should encourage the private provider to come to the facility to provide the services. Approval for private provider care must be approved by the Correctional Health Care Administrator or designee.
- .11 Medical reviews of any inmates to be transferred to another correctional facility shall include consideration of any pending dental work. Should an inmate's pending transfer involve a facility at which an institutional dentist is not readily available and the inmate has major uncompleted dental work pending, the inmate shall not be transferred until dental services have been completed.
- .12 All dental records shall be confidential. These records shall be maintained for all patients and shall include as indicated the:

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- a. Dental Treatment Record, DOC 0409 (Attachment C).
  - b. Dental Health Questionnaire, DOC 0411 (Attachment D).
  - c. Refusal to consent to Medical/Surgical Treatment/Medication, DOC 0417 (Attachment E).
  - d. Dental Examinations.
  - e. Consent to Operation, Post Operative..., DOC 0427, (Attachment B).
  - f. Perio Chart.
  - g. Dental Problem Sheet, DOC 0475 (Attachment F).
  - h. Medical Needs Memo, DOC 0449 (Attachment G).
  - i. Consultation Record, doc 0406 (Attachment H).
  - j. X-rays.
- .13 When an inmate transfers to another PSD facility, the dental record shall be packed with the medical record and transferred according to P & P COR.10E.03, The Transfer of Medical Records.
- .14 Dental records shall be notated in S-O-A-P or problem oriented format. All notes shall include the client's complaint, the examination, the diagnostic impression, and the treatment and treatment plans.
- .15 Form DOC 0406 Consultation Record shall accompany the inmate to an outside dental referral. DOC 0406 will also be used when a dental consultant comes to the facility. The Consultation Record and the consultant's report shall be filed in the Consultation Index of the medical record. A copy of the consultation Record and consultant's report shall be filed in the dental record.
- .16 All dental staff shall practice universal infection controls and infection controls. Infection control practices are defined by the American Dental Association and the Centers for Disease control and Prevention as including sterilizing

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instruments, disinfecting equipment, and properly disposing of hazardous waste.

No inmate shall be denied dental treatment because of an infectious condition.

- .17 Reviews of dental services will be included in the PSD health services quality assurance program as described in P & P COR.10A.05, Quality Improvement Program.

**5.0 SCOPE**

This policy and procedure applies to all correctional facilities and their assigned personnel.

**APPROVAL RECOMMENDED:**

*Kay A. Bauman*  
\_\_\_\_\_  
Medical Director  
5/21/03  
Date

*Verly J.*  
\_\_\_\_\_  
Correctional Health Care Administrator  
4/3/03  
Date

*Frank D. Dwyer*  
\_\_\_\_\_  
Deputy Director for Corrections  
5.10.03  
Date

**APPROVED:**

*Jane L. Spiveck*  
\_\_\_\_\_  
Director  
5/12/03  
Date

CATEGORY CLASSIFICATION:



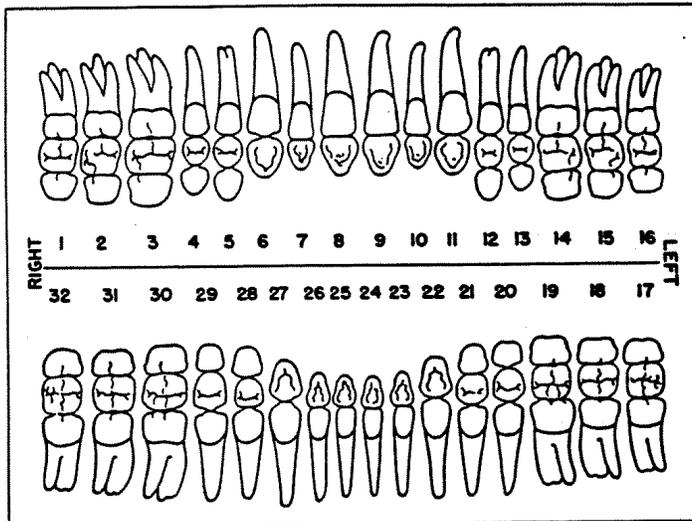
FACILITY \_\_\_\_\_

STATE OF HAWAII  
DEPARTMENT OF PUBLIC SAFETY  
DENTAL EXAMINATION

NAME \_\_\_\_\_ D.O.B. \_\_\_\_\_ SSN \_\_\_\_\_

Date Admitted \_\_\_\_\_ Exam Date \_\_\_\_\_

Medical Alert \_\_\_\_\_



Classifications:

Plaque \_\_\_\_\_

Stain \_\_\_\_\_

Calculus deposits \_\_\_\_\_

Slight \_\_\_\_\_ Mod \_\_\_\_\_ Severe \_\_\_\_\_

Gingiva \_\_\_\_\_

Recession \_\_\_\_\_

Periodontal Condition \_\_\_\_\_

Prosthetics: FUD FLD PUD PLD

B. EXTRAORAL INSPECTION

- Face .....
- Head .....
- Neck .....
- Lymph Nodes .....
- TMJ .....

Normal      Abnormal

COMMENTS: \_\_\_\_\_

C. ORAL INSPECTION

- Lips .....
- Vestibule .....
- Mucosa .....
- Pharynx .....
- Tonsils .....
- Gingiva .....
- Palate .....
- Tongue .....
- Floor of the Mouth .....

	Normal	Abnormal

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

CONSENT TO OPERATION, POST OPERATIVE CARE, MEDICAL TREATMENT, ANESTHESIA, OR OTHER PROCEDURE Patient: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ Facility: \_\_\_\_\_ Date: \_\_\_\_\_

You have the right and obligation to make decisions concerning your health care. The physician must provide you with the information and advice concerning the proposed procedure so that you can make an informed decision

(1) Explain the nature of the condition(s) in professional and ordinary language. PROFESSIONAL: \_\_\_\_\_

Any section below which does not apply to the proposed treatment may be crossed out. All sections crossed out must be initialed by both the physician and the patient.

ORDINARY LANGUAGE: \_\_\_\_\_ AT \_\_\_\_\_

(6) I consent to the administration of (general, spinal, regional, local) anesthesia by my attending physician, by an anesthesiologist, a nurse anesthetist, or other qualified party under the direction of a physician as may be deemed necessary. I understand that all anesthetics involve risks that may result in complications and possible serious damage to such vital organs as the brain, heart, lungs, liver and kidney.

(2) Describe procedures(s) to be performed in professional and ordinary language, if appropriate. PROFESSIONAL: \_\_\_\_\_

These complications may result in paralysis, cardiac arrest and related consequences or death from both known and unknown causes.

ORDINARY LANGUAGE: \_\_\_\_\_ AT \_\_\_\_\_

(3) I recognize that, during the course of the operation, post operative care, medical treatment, anesthesia, or other procedure, unforeseen conditions may necessitate my above-named physician and his or her assistants, to perform such surgical or other procedures as are necessary to preserve my life and bodily functions.

(7) I consent to the use of transfusion of blood and blood products as deemed necessary. I have been informed of the risks which are transmission of disease, allergic reactions, and other unusual reactions.

(4) I have been informed that there are many significant risks, such as severe loss of blood, infection, cardiac arrest and other consequences that can lead to death or permanent or partial disability, which can result from any procedure.

(8) Any tissue or part surgically removed may be disposed of by the hospital or physician in accordance with accustomed practice.

(5) No promise or guarantee has been made to me as to result or care.

(9) Any additional comments may be inserted here: \_\_\_\_\_  
(10) I have had the opportunity to ask questions about this form.

FULL DISCLOSURE

[ ] I AGREE TO AUTHORIZE THE PROCEDURE DESCRIBED ABOVE AND I AGREE THAT MY PHYSICIAN HAS INFORMED ME OF THE:

- a) DIAGNOSIS OR PROBABLE DIAGNOSIS.
b) NATURE OF THE TREATMENT OR PROCEDURE RECOMMENDED.
c) RISKS OR COMPLICATIONS INVOLVED IN SUCH TREATMENT OR PROCEDURES.
d) ALTERNATIVE FORMS OF TREATMENT, INCLUDING NON-TREATMENT, AVAILABLE.
e) ANTICIPATED RESULTS OF THE TREATMENT.

Patient/Other Legally Responsible Person Sign, If Applicable

Date

Physician

Date



## DENTAL HEALTH QUESTIONNAIRE

NAME: \_\_\_\_\_ SSN: \_\_\_\_\_  
 (LAST) (FIRST) (MI)

FACILITY: \_\_\_\_\_ DOB: \_\_\_\_\_ SID: \_\_\_\_\_

In the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

- |     |  |     |    |
|-----|--|-----|----|
| 1.  | Has there been any change in your general health within the past year  | YES | NO |
| 2.  | My last dental/physical examination was on _____   | YES | NO |
| 3.  | Are you under the care of a physician<br>If so, what is the condition being treated _____                                  | YES | NO |
| 4.  | Have you had any serious illness or operation<br>If so, what was the illness or operation _____                            | YES | NO |
| 5.  | Have you been hospitalized or had a serious illness within the past 5 years<br>If so, what was the problem _____           | YES | NO |
| 6.  | Do you have or have you had any of the following diseases or problems:   | YES | NO |
|     | a. Rheumatic fever or rheumatic heart disease  | YES | NO |
|     | b. Heart problems (heart trouble, heart attack, coronary insufficiency, coronary occlusion, arteriosclerosis, stroke)      | YES | NO |
|     | c. High blood pressure   | YES | NO |
|     | d. Allergy   | YES | NO |
|     | e. Sinus trouble   | YES | NO |
|     | f. Asthma or hay fever   | YES | NO |
|     | g. Fainting spells or seizures   | YES | NO |
|     | h. Diabetes  | YES | NO |
|     | i. Hepatitis, jaundice or liver disease  | YES | NO |
|     | j. Arthritis   | YES | NO |
|     | k. Inflammatory rheumatism (painful swollen joints)  | YES | NO |
|     | l. Stomach ulcers  | YES | NO |
|     | m. Kidney trouble  | YES | NO |
|     | n. Tuberculosis  | YES | NO |
|     | o. Low blood pressure  | YES | NO |
|     | p. Venereal disease  | YES | NO |
|     | q. AIDS, HIV+, HIV-  | YES | NO |
|     | r. Other   | YES | NO |
| 7.  | Have you had abnormal bleeding associated with previous extraction's, surgery, or trauma                                   | YES | NO |
|     | a. Do you bruise easily  | YES | NO |
|     | b. Have you ever required a blood transfusion<br>If so, explain the circumstances _____                                    | YES | NO |
| 8.  | Do you have any blood disorder such as anemia  | YES | NO |
| 9.  | Have you had surgery or X-ray treatment for a tumor, growth or other condition of your head or neck                        | YES | NO |
| 10. | Are you taking any drug or medicine<br>If so, what _____   | YES | NO |
| 11. | Are you allergic or have you reacted adversely to any medicines  | YES | NO |
| 12. | Have you had any serious trouble associated with any previous dental treatment<br>If so, explain _____                     | YES | NO |
| 13. | Do you have any disease, condition, or problem not listed above that you think I should know about<br>If so, explain _____ | YES | NO |

\_\_\_\_\_  
 Signature of patient & date

STATE OF HAWAII  
DEPARTMENT OF PUBLIC SAFETY

REFUSAL TO CONSENT TO MEDICAL/SURGICAL/DENTAL TREATMENT/MEDICATION

NAME: \_\_\_\_\_ SSN: \_\_\_\_\_ SID: \_\_\_\_\_

DOB: \_\_\_\_\_ FACILITY: \_\_\_\_\_ DATE: \_\_\_\_\_ TIME: \_\_\_\_\_

I, the undersigned patient, refuse the following treatment and/or medication: \_\_\_\_\_

\_\_\_\_\_  
(Describe Treatment and/or Medication)

The risk of refusing treatment or medication has been explained to me and I accept the risk involved. I release the State, the Department, the facility, the Health Care Division, and its medical personnel from any responsibility whatever for any unfavorable reaction, outcome, or any untoward results due to this refusal on my part to accept treatment or medication.

\_\_\_\_\_  
(Print Name of Patient)                      (Signature of Patient)\*                      (Date)

I, the undersigned, have explained to the above named patient the risk involved in refusing treatment or medication recommended for the patient's continued good health.

\_\_\_\_\_  
(Print Name)                      (Signature & Title)                      (Date)

A referral has been made to the attending physician:                      YES                      NO

I have reviewed this case and if necessary have further counseled this patient on the risk of refusing treatment or medication.

\_\_\_\_\_  
(Print Name of Provider)                      (Signature & Title)                      (Date)

*\* If the patient refuses treatment and/or medication and refuses to sign this consent, please have refusal witnessed by another correctional employee.*

I have witnessed the above named patient refuse the recommended treatment or medication and I have also witnessed the patient's refusal to sign this consent form.

\_\_\_\_\_  
(Print Name & Title)                      (Signature & Title)                      (Date)

DOC 0417 (3/95)

CONFIDENTIAL

STATE OF HAWAII

DEPARTMENT OF PUBLIC SAFETY

**DENTAL PROBLEM SHEET**

Name: \_\_\_\_\_

Facility: \_\_\_\_\_

	Problem	Date Observed	Date Completed	NOTES
1.				
2.				
3.				
4.				
5.				
6.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				
21.				
22.				
23.				
24.				

DOC 0475 (6/92)

**CONFIDENTIAL**

**MEDICAL NEEDS MEMO**

Facility: \_\_\_\_\_

Date: \_\_\_\_\_

TO: \_\_\_\_\_

FROM: \_\_\_\_\_

(Signature/Title of Provider)

Inmate \_\_\_\_\_  
(Print Inmate's Name)

Housed in \_\_\_\_\_

DURATION: \_\_\_\_ Days; \_\_\_\_ Weeks; \_\_\_\_ Months; \_\_\_\_ Indefinitely

*\*Duration not to exceed three months for medication reviews for chronic illnesses.  
\*Health Status Classification Report required if there is a significant change in health status.*

Original: UTM/ACO/Work Supervisor  
Canary: Medical Record  
Pink: Inmate

DOC 0449 (12/2002)

CONFIDENTIAL



	DEPARTMENT OF PUBLIC SAFETY	EFFECTIVE DATE: 05/06/2003	POLICY NO.: COR.10.1G.11
	CORRECTIONS ADMINISTRATION POLICY AND PROCEDURES	SUPERSEDES (Policy No. & Date): COR.10D.34 06/04/2002	
	SUBJECT: <b>PROSTHESES</b>	Page 1 of 3	

No. 2003-305

**1.0 PURPOSE**

To establish guidelines for the purchase of medically indicated prostheses and mechanical devices.

**2.0 REFERENCES AND DEFINITIONS**

**.1 References**

- a. Hawaii Revised Statutes, Section 26-14.6, Department of Public Safety; and Section 353-2, Director of Public Safety, Powers and Duties.
- b. National Commission on Correction Health Care, Standards for Health Services in Prisons and Jails (2003).
- c. American Correctional Association, Standards for Adult Correctional Institutions, (1990), 3-4358.

**.2 Definitions**

- a. Prostheses: Artificial devices to replace missing body parts or compensate for defective physical functions.
- b. Orthotic Devices: Corrective shoes and shoe appliances for treatment of foot and lower limb defects.
- c. Mechanical Prostheses: Motorized or mobile prostheses such as wheelchairs.
- d. Correctional Health Care Administrator (CHCA): Administrator for the Health Care Division (HCD), Department of Public Safety (PSD).
- e. Health Authority: The physician, health administrator, or agency responsible for the provision of health care services at an institution or system of institutions; the Clinical Section Administrator (CSA) is the health authority.

**3.0 POLICY**

- .1 Doctors and dentist may prescribe medically necessary prostheses when indicated to aid function or when the health of the patient is otherwise adversely affected.
- .2 The patient is responsible for the cost and care of the prosthetic or mechanical device. The patient's mandatory minimum sentence, his or her ability to pay for the prosthesis and more cost effective alternatives shall be considerations when approving a prosthetic purchase.

COR P & PM	SUBJECT:  PROSTHESES	POLICY NO.: COR.10.1G.11
		EFFECTIVE DATE: 05/06/2003
		Page 2 of 3

- .3 Authorizations is required by the CHCA for recommended prosthetics and mechanical devices in excess of two hundred dollars (\$200.00).
- .4 All outstanding medical cost obligations shall be deducted from the inmate's account prior to the release of any account balance to the inmate.

**4.0 PROCEDURES**

- .1 No prosthetic or mechanical device shall be removed from an inmate during intake into any facility without first notifying the Health Care Section (HCS). If HCS staff indicates that the device is not medically necessary, it will be removed and recorded and managed as the inmate's property.
- .2 An inmate shall be permitted to wear any prosthesis brought in from the community upon authorization by HCS staff. HCS staff shall take security issues into consideration when granting authorization.
- .3 Provisions shall be made for an inmate to purchase or maintain medical or dental prostheses, including corrective lenses, dentures, artificial limbs, wheelchairs and orthopedic appliances when ordered by the treating physician or dentist.
- .4 Any inmate with a physical disability can request a prosthetic through the regular sick call procedure. If the treating physician or dentist determines that the prosthesis is necessary, the inmate's request shall be referred to the facility health authority for recommendation. The facility health authority must secure authorization from the CHCA prior to payment for prosthetic purchases in excess of two hundred (\$200.00).
  - a. Except for security considerations, no authorization is required for prosthetic purchases, regardless of the expense, if the inmate pays the prescribed prosthesis in full at the time of purchase.
  - b. No special authorization by the CHCA is required for purchases by inmates who use the health care payment plan to purchase prosthetics that cost less than two hundred (\$200.00) dollars. The facility health authority or designee is responsible for approving such purchases. The patient's mandatory minimum sentence, his or her ability to pay and cost effective alternatives shall be considerations during the approval process. Prosthetic purchases are subject to audit.
  - c. If the inmate has insufficient funds in his/her account to cover the full cost of the prosthesis and the cost of the prosthetic is over \$200.00, authorization must be obtained by the CHCA. If authorized by the CHCA, the request shall be referred to the appropriate community provider or laboratory for construction of the device.

COR P & PM	SUBJECT:  PROSTHESES	POLICY NO.: COR.10.16.11 <i>88</i>
		EFFECTIVE DATE: 05/06/2003
		Page 3 of 3

5. When a payment plan is established for authorized purchases by inmates with insufficient funds, the funds shall be withdrawn from the inmate's account whenever there is more than ten dollars (\$10.00) in the account. Use a joint voucher to transfer funds from the inmate's account to the facility's HCS operating fund if the transfer is made during the fiscal year that the prosthesis is purchased. After completion of the fiscal year, the funds shall be made out to the Director of Finance and transferred to the general fund. The inmate shall sign form DOC 0477, Prostheses Purchase Agreement (Attachment A) to authorize withdrawal of funds to pay for the prostheses.
6. In the case of furloughed inmates, a collection of at least one-half the cost of the prosthesis will be made at the time of the initial examination and measurement. The balance shall be an agreed upon amount paid at regular intervals. Any purchase in excess of \$200.00 requires the authorization of the CHCA. Payment shall be made to the HCS by cashier's check or money order. The furloughed inmate shall sign Form DOC 0477-B Furloughee Prosthesis Purchase Agreement (Attachment B).
7. An inmate may refuse the purchase of a recommended prosthetic. A refusal of a prosthetic by an inmate shall be documented on form DOC 0417, Refusal to Consent to Medical/Dental Treatment/Medications (Attachment C).

5.0 SCOPE

This policy and procedure applies to all correctional facilities and their assigned personnel.

APPROVAL RECOMMENDED:

*Key A. Bauma MD* 5/2/03  
 Medical Director Date

*Wally J.* 4/30/03  
 Correctional Health Care Administrator Date

*Frank Lopez* 5.4.03  
 Deputy Director for Corrections Date

APPROVED:

*James L. Spethack*  
 Director  
 5/06/03  
 Date

PROSTHESIS PURCHASE AGREEMENT

\_\_\_\_\_  
(Print Inmate's Name) (SSN) (SID) (DOB)

- \_\_\_\_\_  
(initial) 1. I have been informed about the prosthesis that I wish to purchase. I understand that I am responsible for the cost of the prosthesis and that I am buying the prosthesis from a private business and not from the Department of Public Safety.
- \_\_\_\_\_  
(initial) 2. I understand that if I agree to purchase the prosthesis, and I have sufficient funds in my account to pay for the full cost of the prosthesis, the entire amount will be deducted from my account.
- \_\_\_\_\_  
(initial) 3. The Health Care Section (HCS) has a reimbursement payment plan available if I do not have money in my account to pay for the entire cost of the prosthesis. If I agree to the payment plan, the HCS will purchase the prosthesis from the private business so I can have it right away. I will be obligated to the terms of the payment plan for the entire cost of the prosthesis.
- \_\_\_\_\_  
(initial) 4. I understand I have the right to refuse the recommended prosthesis and the payment plan.
- \_\_\_\_\_  
(initial) 5. If I agree to the payment plan, I understand that whenever there are funds in my account in excess of ten dollars (\$10.00), the excess will be withdrawn until the prosthesis is paid in full.
- \_\_\_\_\_  
(initial) 6. I understand that if I agree to the payment plan and I am released from jail or prison before I have finished paying for the prosthesis, any funds remaining in my inmate account will be applied to my debt. I understand that if I ever return to jail or prison, I will be obligated to pay any outstanding balance owed the Health Care Section for the purchase of the prosthesis as soon as funds are deposited into my account, for any reason, from any source.
- \_\_\_\_\_  
(initial) 7. I understand that the prosthesis is non-refundable once it is made to specifications. A prosthesis may be substituted for an item of equal value if the vendor's regulations allow for exchanges.

- I refuse the payment plan and I do not wish to purchase the prosthesis at this time. \_\_\_\_\_  
(initial)
- I consent to the purchase of the following prosthesis \_\_\_\_\_ and authorize the amount of \$ \_\_\_\_\_ to be deducted in full or by the reimbursement payment plan if I have insufficient funds in my account at this time.  
(initial)

\_\_\_\_\_  
(Inmate Signature) (Date)

\_\_\_\_\_  
(Staff Signature/Title) (Date)

Prosthesis ordered on \_\_\_\_\_ from \_\_\_\_\_.

Prosthesis received on \_\_\_\_\_ Issued to inmate on \_\_\_\_\_ (I/M initial)

Original sent to fiscal on \_\_\_\_\_

Original: Fiscal  
Canary: Medical Record  
Pink: Inmate

DOC 0477 (07/02)

CONFIDENTIAL

**FURLOUGHEE PROSTHESIS PURCHASE AGREEMENT**

If my funds are insufficient to cover the cost of the prosthesis, I understand that a cashier's check or money order amounting to half the cost of the prosthesis shall be paid to the Department to purchase the following prosthetic:

\_\_\_\_\_  
(Type of Prosthetic)

A minimum of \$ \_\_\_\_\_ shall be paid at regular intervals every \_\_\_\_\_ until the cost of the prosthesis is paid in full.

\_\_\_\_\_  
Furlougee's Signature

\_\_\_\_\_  
Date

Original: Fiscal Office  
Canary: Medical Record  
Pink: Inmate

DOC 0477-B (02/02)

CONFIDENTIAL

NOT CONFIDENTIAL

	<b>DEPARTMENT OF PUBLIC SAFETY</b>	<b>EFFECTIVE DATE:</b> FEB 6 1999	<b>POLICY NO.:</b> COR.10D.18
	<b>CORRECTIONS ADMINISTRATION POLICY AND PROCEDURES</b>	<b>SUPERSEDES (Policy No. &amp; Date):</b> NEW	
	<b>SUBJECT:</b> INMATE MEDICAL CO-PAYMENT PLAN	Page 1 of 5	

No. 99-483

1.0 **PURPOSE**

To provide guidelines and an organized process for inmate co-payments of certain medical services.

2.0 **REFERENCES AND DEFINITIONS**

.1 References

- a. Hawaii Revised Statute, Chapter 353, 1998.
- b. Journal of Correctional Health Care, Volume 3, Issue 2, Fall 1996.
- c. Martin v. DeBruyn, 880 F. Supp. 610 (N.D. Ind. 1995).

.2 Definitions

- a. Co-payment: A nominal amount paid by offenders for certain health care services.
- b. Indigent: An inmate with less than ten dollars (\$10.00) of income in his or her spendable and/or restricted accounts.
- c. Dental treatment: The treatment of dental problem based on a prioritized triage system.
- d. Health Care Provider: An individual certified or licensed to deliver health care services.
- e. Health Care Services: Medical, dental, mental health and health information services.
- f. NCCHC: The National Commission on Correctional Health Care standards are the recommended minimum requirements for prison health services.
- g. Episode of care: From the beginning of treatment for injury or illness until there is no longer any required follow-up care as determined by the health care provider.
- h. Infirmary: A designated area within a facility that is expressly set up and operated for the purpose of caring for patients who do not need hospitalization, but whose care can not be managed safely in an outpatient or in a general population setting.
- i. Retrospective Billing System: This is not an accounting method. The terminology describes a system that charges the patient for medical services after the service is rendered to ensure access to health care.

COR P & PM	SUBJECT:  INMATE MEDICAL CO-PAYMENT PLAN	POLICY NO.: COR.10D.18
		EFFECTIVE DATE: FEB 6 2000
		Page 2 of 5

3.0 POLICY

Inmates shall not be denied access to health care or treatment because of their inability to pay the co-payment fee. There shall be a retrospective billing system for services rendered.

4.0 PROCEDURES

- .1 Inmates shall be informed on admission about their responsibility to the medical co-payment plan, the self-purchase/self-administration over-the-counter medication program, prosthetic purchases and other information regarding health care services. The information shall be in the form of a pamphlet. A poster describing access to health care shall be displayed in intake sections.
- .2 On the fourteen (14) day physical, the inmate shall sign an agreement that informs him or her of the medical co-payment for inmate initiated services, and the inmate's responsibility regarding other medical services, on Form DOC 0459, Medical Co-Payments, Over-The-Counter Medications, Prosthetics Purchase Agreement (Attachment A).
- .3 There shall be a co-payment charge of three dollars (\$3.00) per visit for identified medical, mental health and dental services. There will be no charge for a return to clinic if ordered by the physician for an episode of care. Subsequent visits related to the initial request shall include a co-payment if not initiated or scheduled by a health care provider.
- .4 For clinical services, before the end of each watch for large facilities or no later than the end of each day for small facilities, assigned medical staff shall total the co-payment cost of services and medications provided to each inmate on Form DOC 0414, Co-Payment Cost For Medical Services (Attachment B). The forms shall be submitted to the facility fiscal office every Monday. On holidays that fall on a Monday, the forms should be submitted to the facility fiscal office on the Friday preceding the Monday holiday.
- .5 For infirmary services related to inmate elected medical procedures, the inmate shall pay the full cost of the infirmary stay per day. The cost shall be estimated using per day cost of semi-private rooms in a community hospital (e.g. Hilo Hospital, Maui Memorial, Liahui Hospital) The inmate will pay the full cost of any medications or medical supplies that by necessity are prescribed by the health care provider. The inmate must have sufficient funds to cover the estimated cost of the infirmary stay prior to the elected procedure. The charges shall be totaled and submitted to the facility fiscal office on the day of discharge. For calculating the infirmary length of stay, the date of admission shall not be counted. The date of discharge shall be counted. An admission and release on the same day is counted as one day.
- .6 The inmate shall be billed after the service is provided. The co-payment charge shall be deducted from the inmate's account at the time the charges are filed and if there is a balance of over ten dollars (\$10.00) in the account. If there is more than ten dollars in the account but less than the total co-payment amount owed by the inmate, the difference shall be deducted from the account.

COR P & PM	SUBJECT:  INMATE MEDICAL CO-PAYMENT PLAN	POLICY NO.: COR.10D.18
		EFFECTIVE DATE: APR 6 2009
		Page 3 of 5

- .7 If an inmate is indigent at the time the charge is posted, the facility fiscal officer shall so indicate on DOC Form 0414 and return the form to the Health Care Section. The inmates debt will be resubmitted with the next batch of names on the following Monday.
- .8 If an inmate discovers a billing error relating to the medical co-payment, he or she may request a review of the bill by the nurse manager. Items still in dispute will be submitted to the Health Information Branch Administrator for review. Any item still in dispute will be submitted to an independent appeals board.
- .9 The facility Clinical Services Section shall submit to the Director through the chain-of-command, with a copy to the Warden, an annual comparison study of the amount (in percentages) by which medical request by inmates has been reduced for non-essential medical services compared to the previous calendar year.
- .10 The facility fiscal office shall submit to the Director through the chain-of-command, with a copy to the facility nurse manager, the annual amount of funds recovered by the facility through the inmate co-payment plan for the calendar year.
- .11 The following services are exempt from the medical co-payment fee:
  - a. Medical, mental health, and dental admission screenings, examinations, and diagnostic tests required by law, a Consent Decree or the NCCHC standards.
  - b. Mental health services for inmates in special housing or holding units, therapeutic housing, or transitional housing units.
  - c. Mental health referrals by medical staff or correctional employees.
  - d. A first visit with mental health staff by request from a general population inmate for any episode of care requiring assessment of the inmate's mental health.
  - e. Inmate requested diagnostic testing for suspected sexually transmitted diseases, HIV/AIDS, tuberculosis, or hepatitis.
  - f. Clinic visits to assess or clear an inmate for transfer, assignment to programs, work assignments, treatment facilities, or therapeutic communities.
  - g. Physician ordered infirmary admissions.
  - h. Industrial injuries.
  - h. Visits scheduled at the request of a health care provider. These visits may include, but are not limited to:
    - 1. Diagnosis, treatment and care of communicable diseases;

<b>COR</b> <b>P &amp; PM</b>	<b>SUBJECT:</b>  <b>INMATE MEDICAL CO-PAYMENT PLAN</b>	<b>POLICY NO.:</b> <b>COR.10D.18</b>
		<b>EFFECTIVE DATE:</b> <b>FEB 6 2008</b>
		<b>Page 4 of 5</b>

2. Diagnosis, treatment and care of chronic illnesses, including regularly scheduled clinics or workshops for chronic disease management;
  3. Dietetic consultations for chronic disease management;
  4. Pre- and post-natal care and examination.
- .11 Inmates shall be charged a co-payment for the following services:
- a. Inmate requested medical, mental health (except as stated above) and dental treatment;
  - b. Inmate requests for a dietetic consultation not related to a medical condition or a chronic disease.
- .12 Except for mentally ill inmates in special housing units, inmates shall pay the co-payment fee when treated for self inflicted wounds or self induced injury. This includes, but is not limited to:
- a. Self inflicted wounds or injury
  - b. Fights with other inmates or staff, or deliberately punching, kicking, hitting, banging, etc., movable or immovable objects;
  - c. Recreational injuries.
  - d. Accidental or injuries.

COR P & PM	SUBJECT:  INMATE MEDICAL CO-PAYMENT PLAN	POLICY NO.: COR.10D.18
		EFFECTIVE DATE: FEB 6 1999
		Page 5 of 5

SCOPE

This policy and procedure applies to all Correctional facilities and their assigned personnel.

APPROVAL RECOMMENDED:

*Kenneth Stuberwey, MD*  
Health Care Division Administrator

2/1/99  
Date

\_\_\_\_\_  
Deputy Director for Corrections

\_\_\_\_\_  
Date

APPROVED:

*W. S. D.*  
\_\_\_\_\_  
Director

2/6/99  
Date

DEPARTMENT OF PUBLIC SAFETY

INMATE MEDICAL CO-PAYMENT, PROSTHETICS, AND OVER-THE-COUNTER MEDICATION PURCHASES AGREEMENT

Facility \_\_\_\_\_

Date: \_\_\_\_\_

1. Did you receive a pamphlet at intake that describes the Department's medical services for inmates? YES  NO
2. If you answered no to question number one, have you been issued a pamphlet by the nurse during this interview? YES  NO  N/A
3. Have you been informed by the nurse about inmate medical co-payments? YES  NO
4. Have you been informed by the nurse about inmate prosthetic purchases? YES  NO
5. Have you been informed by the nurse about over-the-counter medication purchases from the commissary (inmate store)? YES  NO

By signing this form, you are agreeing that you have been informed of the inmate medical co-payment plan and your responsibility to pay a three dollar (\$3.00) co-payment fee when you seek non-emergency medical treatment. Treatment for communicable diseases, chronic diseases, emergency treatment, and medical screenings are exempt from the inmate medical co-payment. By signing this form you are also agreeing that you have been informed about purchasing prosthetics and over-the-counter medications.

\_\_\_\_\_  
Print Name of Inmate

\_\_\_\_\_  
Name and Title of Health Care Staff

\_\_\_\_\_  
Inmate's Signature

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

Original: Medical Record (Consent Index)  
Canary: Inmate's Copy

DOC 0459 (7/98)

CONFIDENTIAL



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## A BILL FOR AN ACT

RELATING TO CORRECTIONS.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

1 SECTION 1. Chapter 353, Hawaii Revised Statutes, is amended  
2 by adding a new section to be appropriately designated and to  
3 read as follows:

4 "§353- Nonemergency medical, dental, mental health  
5 services or treatment; intentional injury; payment by inmates.

6 (a) The department of public safety may develop policies and  
7 procedures governing the assessment of fees upon detainees and  
8 committed persons who receive certain medical, dental, or mental  
9 health services or treatment. In adopting these policies and  
10 procedures, the department shall safeguard the health and welfare  
11 of detainees and committed persons.

12 (b) The policies and procedures shall enable the department  
13 to assess fees upon detainees and committed persons who:

14 (1) Request certain nonemergency medical, dental, or mental  
15 health services or treatment; or

16 (2) Intentionally inflict injury to themselves.

17 (c) The policies and procedures shall include an appeals  
18 process to allow a detainee or committed person to appeal the  
19 assessment.

SB2249 CD1 JDC

1        (d) The department of public safety may adopt policies and  
2 procedures to establish a fee schedule for medical, dental, and  
3 mental health services or treatment under the following  
4 conditions:

5        (1) Fees shall be assessed from the detained or committed  
6 person's individual trust account pursuant to section  
7 353-20; and

8        (2) Fees shall not be assessed if the individual trust  
9 account balance is less than \$10; provided that the  
10 department may implement a procedure to recover fees in  
11 the future."

12        SECTION 2. One year after the start of the implementation  
13 of the assessment of fees for medical, dental, and mental health  
14 services or treatment, the department of public safety shall  
15 submit a report to the legislature that summarizes the total of  
16 moneys deducted from inmate accounts. The report shall include  
17 an estimate of savings to the department through the related  
18 reduction in nonemergency medical, dental, or mental health  
19 services or treatment, and intentional injuries.

20        SECTION 3. New statutory material is underscored.

21        SECTION 4. This Act shall take effect upon its approval.

APPROVED BY THE  
GOVERNOR ON

JUL 20 1998

"The Policies and Procedures for Tool/Equipment Control, Policy No COR.08-27, have been marked 'Confidential' and will be provided to the Provider awarded this contract.

The Provider (Contractor) shall comply with Policy No COR.08.27 titled: 'Tool/Equipment Control'. The Provider shall be responsible to maintain a complete inventory of all tools utilized in the performance of their services. Inventory of tools shall be done on a daily basis at the beginning of each work day and at the close of each work day. A monthly tool audit shall be conducted by the Provider and forwarded to the Tool Control Officer. All inventory records shall be subject to inspection by the Chief of Security and or Tool Control Officer."



STATE OF HAWAII  
DEPARTMENT OF PUBLIC SAFETY

TOOL/EQUIPMENT RECEIVING REPORT

TO: Chief of Security  
FROM: Tool Control Officer

On \_\_\_\_\_, a \_\_\_\_\_  
(date) (Name and Number of Tools)

for \_\_\_\_\_, was received at the Institution.  
(Section/Unit)

This classification for this tool is \_\_\_\_\_.

This tool was etched and/or color coded to conform to Policy Statement.

Signature: \_\_\_\_\_  
(Tool Control Officer)

cc: Tool Control Officer  
Work Area Supervisor for whom the tool was purchased.

DOC 82357 (11/90)

[Master doc #0096m]



STATE OF HAWAII  
DEPARTMENT OF PUBLIC SAFETY

**MEMORANDUM**

To: TOOL CONTROL OFFICER Date: \_\_\_\_\_

From: \_\_\_\_\_ Reply Due: \_\_\_\_\_

Subject: RESTRICTED TOOL WEEKLY INVENTORY

This is to certify that all restricted tools assigned to the \_\_\_\_\_  
Shop have been physically inventoried and accounted for on this date.

\_\_\_\_\_  
Supervisor Date

Additional Remarks: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PSD 1005 (7/90)

STATE OF HAWAII  
DEPARTMENT OF PUBLIC SAFETY

**MEMORANDUM**

To: TOOL CONTROL OFFICER Date: \_\_\_\_\_

From: \_\_\_\_\_ Reply Due: \_\_\_\_\_

Subject: MONTHLY TOOL/EQUIPMENT INVENTORY

This is to certify that all tools/equipment itemized on the attached Tool/Equipment Inventory Forms have been physically inventoried and accounted for on this date.

\_\_\_\_\_  
Supervisor Date

Additional Remarks: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PSD 1005 (7/90)



STATE OF HAWAII  
DEPARTMENT OF PUBLIC SAFETY

LOST TOOL/EQUIPMENT REPORT

TO: Chief of Security

Date: \_\_\_\_\_

FROM: Name: \_\_\_\_\_  
Title: \_\_\_\_\_  
Section/Unit: \_\_\_\_\_

The tool(s) listed below have been lost/stolen from this work site on this date: \_\_\_\_\_.

<u>DESCRIPTION OF TOOL(S)</u>	<u>NUMBER MISSING</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Circumstances surrounding this loss are as described below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

cc: Tool Control Officer  
Watch Supervisor  
Work Area Supervisor

DOC 8259 (11/90)

[Master doc #0097m]



NOT CONFIDENTIAL

	<b>DEPARTMENT OF PUBLIC SAFETY</b>	<b>EFFECTIVE DATE:</b> NOV 16 1998	<b>POLICY NO.:</b> COR.10F.01
	<b>CORRECTIONS ADMINISTRATION POLICY AND PROCEDURES</b>	<b>SUPERSEDES (Policy No. &amp; Date):</b> COR.10F.01 07/16/96	
	<b>SUBJECT:</b> <b>INFORMED CONSENT</b>	<b>Page 1 of 4</b>	

No. 98-47674

1.0 **PURPOSE**

To provide guidelines for rendering medical examinations, treatments, and other medical procedures which require informed consent

2.0 **REFERENCES AND DEFINITIONS**

Section 26-14.6, Department of Public Safety; and Section 353C-2, Director of Public Safety, Powers and Duties.

.1 References

- a. National Commission on Correctional Health Care, Standards for Health Services in Prisons, (1997), P-70, Jails, (1996), J-67.
- b. National Commission on Correctional Health Care, Standards for Health Services, (1997), Right to Refuse Treatment, P-71, Jails, (1996), J-68.
- c. National Commission on Correctional Health Care, Standards for Health Services in Prisons, (1997), Medical Research, P-72, Jails, (1996), J-69.
- d. American Correctional Association, Standards for Adult Correctional Institutions, (1990), Informed Consent, 3-4372.
- e. American Correctional Association, Standards for Adult Correctional Institutions, (1990), Inmate Participation in Research, 3-4373.
- f. Hawaii Revised Statutes, 352-8, 671-3.

.2 Definitions

- a. Informed Consent: Voluntary consent or agreement by a patient to a treatment, examination, or procedure after they have received the significant facts regarding the condition being treated and the nature, consequences, risks, benefits, and alternatives concerning the proposed examination, procedure, or treatment, including the right of refusal.
- b. Attending Physician: A doctor of medicine or osteopathy who is rendering the treatment, examination, or procedure to the patient.

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3.0 **POLICY**

- .1 Information exchanged between a health care provider and a patient while rendering health care is privileged and confidential.
- .2 Health care professionals shall promote trust between health care providers and patients. In this respect, health care professionals shall not participate in any activity or perform a procedure or treatment on a patient that aids or will result in disciplinary action.
- .3 Informed consent by a patient shall be required for those examinations, treatments, and procedures that are intrusive or governed by informed consent standards in the community.
- .4 The health care provider attending the patient shall be responsible for informing the patient of the condition and recommended procedure or treatment, and any risk that may be involved in the treatment, including available alternatives.
- .5 A competent patient has the right to refuse medical care.
- .6 In every case in which consent is waived by the health care provider, reasons for the decision to undertake the procedure without consent shall be documented in the medical record. The informed consent requirement may be waived for the following reasons:
  - a. An emergency that requires immediate medical intervention for the preservation of life or the safety of the inmate;
  - b. If in the professional opinion of the physician the physical or mental health of others is endangered.
  - c. When a psychiatrist or court of law judges an inmate to be incapable of understanding the information given according to the standard, legally defined criteria of competence.
- .7 Inmates shall not participate in experimental projects involving medical, pharmaceutical, or cosmetic research, including adverse conditioning, psycho-surgery, electrical stimulation of the brain, or the application of

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		EFFECTIVE DATE: MAY 14 1998
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cosmetic substances to the body that are being tested for possible ill effects prior to sale to the general public.

This does not preclude the use of experimental medical procedures or treatments as part of a research protocol passed by an institutional human research review committee and subject to informed consent; nor does it preclude the collection of statistical or epidemiological data on inmates.

#### 4.0 PROCEDURE

- .1 When a patient consents to a treatment or procedure provided by the Health Care section, the attending physician shall ensure that Form DOC 0427, Consent to Operation, Post Operative Care, Medical Treatment, Anesthesia, or Other Procedure (Attachment A), if applicable, is reviewed with and signed by the patient. The attending physician shall enter a narrative progress note indicating the information provided and the results of the discussion with the patient. The clinic nurse shall ensure the form is completed and medical records staff shall file the form under the Consent Index in the medical record.
- .2 When a patient refuses a scheduled medical appointment, medical treatment, surgical procedure, or medications, the patient shall be informed by the health care provider of the consequences and shall be required to sign form DOC 0417, Refusal To Consent To Medical Or Surgical Treatment (Attachment B). The patient's signing of the form shall be witnessed by staff. The attending physician shall review the refusal, and if appropriate, record a narrative statement in the progress notes regarding the refusal. The physician shall sign the form indicating the refusal was reviewed.
- .3 When an inmate refuses medical care and refuses to sign Form DOC 0417, the refusal shall be witnessed by health care staff and facility staff (two people) who shall sign their names and write, 'inmate refused to sign' on the form and the date of refusal. The health care provider shall enter a narrative progress note regarding the refusal and the discussion with the inmate regarding the consequences of refusing treatment.

Inmates diagnosed with contagious or communicable diseases and who refuse treatment shall be medically quarantined by the health care authority, if necessary, to control spread of the disease.

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		EFFECTIVE DATE: REV. 6/1998
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5.0 SCOPE

This policy and procedure applies to all correctional facilities and their assigned personnel.

APPROVAL RECOMMENDED:

*[Signature]*  
Health Care Division Administrator

10/23/98  
Date

*[Signature]*  
Deputy Director for Corrections

11/14/98  
Date

APPROVED:

*[Signature]*  
Director

11/16/98  
Date

CONSENT TO OPERATION, POST OPERATIVE CARE, MEDICAL TREATMENT, ANESTHESIA, OR OTHER PROCEDURE Patient: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ Facility: \_\_\_\_\_ Date: \_\_\_\_\_

You have the right and obligation to make decisions concerning your health care. The physician must provide you with the information and advice concerning the proposed procedure so that you can make an informed decision.

(1) Explain the nature of the condition(s) in professional and ordinary language. Any section below which does not apply to the proposed treatment may be crossed out. All sections crossed out must be initialed by both the physician and the patient.

PROFESSIONAL: \_\_\_\_\_

ORDINARY LANGUAGE: \_\_\_\_\_

AT \_\_\_\_\_

(2) Describe procedure(s) to be performed in professional and ordinary language, if appropriate.

PROFESSIONAL: \_\_\_\_\_

ORDINARY LANGUAGE: \_\_\_\_\_

AT \_\_\_\_\_

(3) I recognize that, during the course of the operation, post operative care, medical treatment, anesthesia, or other procedure, unforeseen conditions may necessitate my above-named physician and his or her assistants, to perform such surgical or other procedures as are necessary to preserve my life and bodily functions.

(4) I have been informed that there are many significant risks, such as severe loss of blood, infection, cardiac arrest and other consequences that can lead to death or permanent or partial disability, which can result from any procedure.

(5) No promise or guarantee has been made to me as to result or care.

(6) I consent to the administration of (general, spinal, regional, local) anesthesia by my attending physician, by an anesthesiologist, a nurse anesthetist, or other qualified party under the direction of a physician as may be deemed necessary. I understand that all anesthetics involve risks that may result in complications and possible serious damage to such vital organs as the brain, heart, lungs, liver and kidney.

These complications may result in paralysis, cardiac arrest and related consequences or death from both known and unknown causes.

(7) I consent to the use of transfusion of blood and blood products as deemed necessary. I have been informed of the risks which are transmission of disease, allergic reactions, and other unusual reactions.

(8) Any tissue or part surgically removed may be disposed of by the hospital or physician in accordance with accustomed practice.

(9) Any additional comments may be inserted here:

\_\_\_\_\_

(10) I have had the opportunity to ask questions about this form.

**FULL DISCLOSURE**

[ ] I AGREE TO AUTHORIZE THE PROCEDURE DESCRIBED ABOVE AND I AGREE THAT MY PHYSICIAN HAS INFORMED ME OF THE:

- a) DIAGNOSIS OR PROBABLE DIAGNOSIS.
- b) NATURE OF THE TREATMENT OR PROCEDURE RECOMMENDED.
- c) RISKS OR COMPLICATIONS INVOLVED IN SUCH TREATMENT OR PROCEDURES.
- d) ALTERNATIVE FORMS OF TREATMENT, INCLUDING NON-TREATMENT, AVAILABLE.
- e) ANTICIPATED RESULTS OF THE TREATMENT.

\_\_\_\_\_  
Patient/Other Legally Responsible Person Sign, If Applicable

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician

\_\_\_\_\_  
Date

DOC 0427 (11/97)

CONFIDENTIAL